2003 PLUS MINIMUM BENEFIT PACKAGE

Revised December 23, 2002

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, MCO must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, MCO must provide a minimum of:
Inpatient Hospital Care	Covered, as medically necessary, with authorization by a Health Plan physician. *This REQUIRED service is included in the capitation payment.*	15 inpatient hospital days per contract year, based on medical necessity. *Fifteen days is the REQUIRED minimum, although the plan has the option of providing more in Contract Year 2003.*	*No change for MCOs. REQUIRED*
Observation	*Observation has never been delineated as a required service in the Plus contract. However, at the plan's request it was added to this document so plans would know if Observation is covered in Oklahoma's Fee-For-Service program for Choice members. If a plan wanted to cover Observation care as medically necessary, that was its OPTION. Cost of observation care was NOT included in capitation payments and would have been funded through plan operational savings.*	Coverage *NOT REQUIRED. No change for MCOs.Plans may cover this as an optional service.*	Coverage *NOT REQUIRED. No change for MCOs. Plans may cover this as an optional service.*
Outpatient Hospital Services (includes Ambulatory Surgery)	Covered, as medically necessary, with authorization by a Health Plan physician. *This REQUIRED service is included in the capitation payment.*	The following services, as medically necessary: dialysis, radiation therapy, ambulance, blood, pharmacy, laboratory, and other services as medically necessary. *These specified services are REQUIRED. MCOs have option of doing more.*	*No change for MCOs. REQUIRED*

Physician Services	Covered, as medically necessary, with authorization by a Health Plan physician. *This REQUIRED service is included in the capitation payment.*	PCP office visits as medically necessary are *REQUIRED*. Specialty care visits may be limited to two per month except when in connection with emergency medical conditions. *If MCOs choose to limit access to specialty care, they are REQUIRED to furnish a minimum of two specialist physician visits per month. MCOs have the option of permitting more specialist care than the minimum.*	All medically necessary physician services. *No change for MCOs. REQUIRED*
Obstetric Care	*Obstetric care services have been referenced as "Covered, as medically necessary" in the body of the Plus contract in the past. Requirements were never as detailed as in the column to the right in the Plus contract. However, at the plan's request this level of detail was added to this document so plans would know how OB care is covered in Oklahoma's Fee-For-Service program. The cost of OB care in Plus has been included in capitation and supplemental delivery payments. OB care continues to be REQUIRED*	Maternity Care and Delivery include all routine care as well as one ultrasound performed by the physician during the maternity cycle. Additional coverage as medically necessary for complete and targeted ultrasound by a specialist, stand-by attendance at C-section, spinal anesthesia, amniocentesis. *OB care is REQUIRED.*	Same as coverage for adults. *No change for MCOs. REQUIRED*

Family Planning Services	Adolescent and adult. Health Plan must allow adolescent (under age 18) members to obtain family planning services from any qualified provider, in- or out-of-network. OHCA will reimburse out-of-network providers of adolescent family planning services on a fee-for-service basis. Contraceptive medical visits, family planning education and counseling, birth control methods ordered at a family planning visit. Tubal ligation for enrollees age 21 or over, per federal guidelines with federally-mandated consent forms. Includes lab services including hematocrit, dipstick UA, Pap smear, GC culture, serologic test for syphilis and rubella screening. Also, treatment of and follow-up for minor gynecological problems and infections. *Family planning services are included in capitation.*	Same as current PLUS benefits (may be subject to physician minimum service limitations) *REQUIRED.*	*No change for MCOs.* *REQUIRED*

Over-the-Counter Contraceptives And Diabetic Supplies	OTC contraceptive devices and products, and diabetic supplies for enrollees (male and female). *Services are REQUIRED and included in capitation payments.*	OTC contraceptives are covered (contraceptives not to count toward prescription limit). *REQUIRED* Diabetic supplies coverage may be limited to: one glucometer, one spring loaded lancet device, and three replacement batteries per year. In addition coverage may be limited to 100 glucose test strips and 100 lancets per month, unless otherwise indicated by medical necessity. *MCOs are REQUIRED to furnish the minimum listed here. Providing more is optional.*	OTC contraceptives as prescribed. *No change for MCOs.* *REQUIRED* Diabetic supplies as needed. *No change for MCOs.* *REQUIRED*
Smoking Cessation Products	A benefit of up to 90 days covered once per twelve months. Any additional coverage is considered on a case by case basis. *Services are REQUIRED and included in capitation payment.*	A 90-day smoking cessation benefit consisting of Zyban, prescription nicotine patches, or Zyban/patch combination once per twelve months when prior authorized. Additional coverage may be considered on a case by case basis. *MCOs are REQUIRED to furnish the minimum listed here. Providing more is optional.*	A 90-day smoking cessation benefit consisting of Zyban, prescription nicotine patches, or Zyban/patch combination once per twelve months when prior authorized. Additional coverage may be considered on a case by case basis. *REQUIRED*

Prescription Drugs	Therapeutic, non-cosmetic prescriptions covered (generic substitution allowed and encouraged) when prescribed by a Health Plan physician, or in accordance with RFP Section 2.5.2. *This REQUIRED service is included in capitation. In addition, some MCOs have used dollars realized through operational savings to expand this benefit to cover non-prescription drugs.*	Three (3) prescriptions per month. Prescriptions for certain medical conditions are not to be included within the three prescription limit include: anti-neoplastics, anti-viral agents for the treatment of opportunistic infections for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS), certain prescriptions which require frequent laboratory monitoring, birth control prescriptions, over-the-counter contraceptives, hemophilia drugs, compensable smoking cessation products, certain solutions used in compounds (i.e., sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. *MCOs are REQUIRED at a minimum to cover three prescription drugs per month for adults.*	All prescriptions as medically necessary. *No change for MCOs.* *REQUIRED*
Outpatient Laboratory, Radiology and other Diagnostic Services	Covered, as medically necessary. *These REQUIRED services are included in capitation.*	No Change. Adults are covered for CT scans. MRIs as medically necessary. *REQUIRED*	No Change. *REQUIRED*
EPSDT Services (State Plan and Non-State Plan)	Covered for all children and young adults up to age 21 years. *These REQUIRED services for children are included in capitation.*	Not applicable	No Change. *REQUIRED*

Home Health Services	Home Health Services including, but not limited to, skilled nursing visits shall be provided as medically necessary, with authorization by a Health Plan physician. *These REQUIRED services are included in capitation.*	36 nurse visits per contract year and standard supplies. *MCOs are REQUIRED at a minimum to provide 36 visits.* Standard supplies include supplies routinely used by nurses during home health visits such as bandages, syringes, wound care supplies, ointments, etc. *MCOs are REQUIRED to provide standard supplies during home health visits.*	No change. Continue to base coverage on medical necessity. However, plan may require prior authorization after 36 home health visits have been utilized. *This is not a change for the MCOs. REQUIRED* *No change for MCOs. REQUIRED*
Dental Services	Comprehensive dental services for members up to age 21 years, including orthodontia, as delineated in State Dental Provider manual. Coverage for members age 21 and older are limited to emergency extractions and reconstructive dental surgery. If the dental condition is causing a substantial detriment to the enrollee's medical condition, then remediation of the dental condition is required. *This is REQUIRED for children only and is included in capitation.* Coverage for members categorized as ABD age 21 and older is limited to emergency dental care, extractions and medically necessary dentures. *This is included in capitation.*	Coverage not required. *MCO is NOT REQUIRED to cover dental services for adults*. Coverage is *NOT REQUIRED* for ABD members age 21 and older.	No Change. *REQUIRED*

Eye Care Services	Comprehensive services for members up to age 21 years, including replacement lenses and frames as medically necessary. Coverage for members age 21 and older limited to treatment of diseases/injuries of the eye. *This service is REQUIRED for children only and included in capitation.* Members categorized as ABD age 21 and over shall have access to vision examination and correction as follows: For adults age 21 to 45, one routine eye exam plus one pair of glasses each 24-month period; for adults age 46 or older, one routine eye exam plus one pair of glasses each 12-month period. This service is included in capitation.	Treatment of eye disease not related to refractive errors. *This is the only REQUIRED service.* Routine exams, treatment of refractive errors, lenses, frames, eye examinations for the purpose of prescribing glasses or for the purchase of visual aids are *NOT REQUIRED. However, the MCO has the option of providing these services.* Coverage is *NOT REQUIRED* for members categorized as ABD age 21 and over. *However, the MCO has the option of providing these services.*	No Change. Coverage *REQUIRED*.
Emergency Room Services	Coverage twenty four hours a day, seven days a week for true medical and behavioral health emergencies, or as authorized by Plan or Plan physician. Coverage complies with the "Prudent Layperson" standard effective with the Balanced Budget Act of 1998. *This is REQUIRED and included in capitation.*	No Change**.** *REQUIRED*	No Change**.** *REQUIRED*

FQHC Services, including physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, or social workers and services and supplies as would otherwise be covered if furnished or incident to a physician's services and ancillary services, subject to limitations in the benefits package for services for adults.	Covered if the individual enrolls with a network FQHC provider as his or her PCP or, in the case of an individual who elects a PCP who is not affiliated with an FQHC, if that provider makes a referral to an FQHC for certain services on a pre-authorized basis. Patients may self-refer to network FQHC dental, vision, obstetrical, behavioral health and family planning providers, as specified by the RFP, subject to the limitations of the benefits package *This is REQUIRED and included in capitation*.	No Change REQUIRED	No Change *REQUIRED*
Short-term skilled, intermediate nursing care and hospice services	Up to 30 days of skilled and intermediate nursing facility care is covered. Hospice services also covered when authorized by a Health Plan physician. *This is NOT REQUIRED and is included in capitation.*	Coverage *NOT REQUIRED. This change means the member will be disenrolled from managed care. Fee for Service does not have a skilled nursing facility benefit. Intermediate nursing facility stays are a covered benefit in Fee for Service.*	Coverage *NOT REQUIRED. This change means the member will be disenrolled from managed care and will become eligible for services under Fee For Service.*

Respite Service	*Respite service has never been delineated as a required service in the Plus contract. However, at the plan's request it was added to this document so plans would know if Respite is covered in Oklahoma's Fee-For-Service program for Choice members. If a plan wanted to cover Respite care as medically necessary, that was its option. Cost of respite care was NOT included in capitation payments and would have been funded through plan operational savings*	No change. Coverage *NOT REQUIRED. MCO has the option of providing this service.*	No change. Coverage *NOT REQUIRED. MCO has the option of providing this service.*
Services in Institutions for Mental Diseases (IMDs)	Covered for individuals under age 21 or over age 65 as specified in the existing State Plan. *This is REQUIRED included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*
Podiatry Services	Non-routine, medically necessary services covered, with authorization by a Health Plan physician. *This REQUIRED service is included in capitation.*	Medically necessary surgical procedures, x-rays, and outpatient visits. *REQUIRED.* Coverage for procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, is *NOT REQUIRED* unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease, establishes the medical necessity for the service. *MCO has the option of covering these services.*	Same as for adults. *REQUIRED*

Durable Medical Equipment, including medical supplies (see definition in Section 1.4).	Covered, as medically necessary, with authorization by a Health Plan physician. All of the following must be met to be considered medically necessary. The supplies or equipment or appliance must be: 1) a reasonable and necessary part of the recipient's treatment plan; 2) consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment; 3) not furnished for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier; and, 4) necessary and consistent with generally accepted medical standard (i.e., not experimental or investigational). *These REQUIRED services are included in capitation.*	Coverage in accordance with Medicare guidelines. *REQUIRED.* Coverage for orally administered and enteral nutritional supplements is *NOT REQUIRED; optional.* Parenteral supplements are to be covered based on permanent inoperative body organ. *REQUIRED* Coverage for orthotics *NOT REQUIRED;* optional.	No Change. *REQUIRED*

Assistive Technology (see definition in Section 1.4).	Covered for individuals under age 21, as medically necessary, with authorization by a Health Plan physician. All of the following must be met to be considered medically necessary. The supplies or equipment or appliance must be: 1) a reasonable and necessary part of the recipient's treatment plan; 2) consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment; 3) not furnished for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier; and, 4) necessary and consistent with generally accepted medical standard (i.e., not experimental or investigational). *REQUIRED* for children under 21 and included in capitation.	Not Applicable.	No Change. *REQUIRED*

Prosthetic Devices	Covered, as medically necessary, with authorization by a Health Plan physician. All of the following must be met to be considered medically necessary. The device or equipment or appliance must be: 1) a reasonable and necessary part of the recipient's treatment plan; 2) consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment; 3) not furnished for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier; and, 4) necessary and consistent with generally accepted medical standard (i.e., not experimental or investigational).*This REQUIRED service is included in capitation.*	Under Medicaid Fee For Service, "Payment for prosthetic devices implanted during surgery is included within the level of care per diem rates except for Vagus Nerve Stimulator and implantable medication pumps. *REQUIRED* Additional payment is optional and may be considered on a case by case basis.	Under Medicaid Fee For Service, "Payment for prosthetic devices implanted during surgery is included within the level of care per diem rates except for: Cochlear Implants, Vagus Nerve Stimulator, and implantable medication pumps. Additional payment may be considered on a case by case basis. *REQUIRED*
Artificial Limbs	*Artificial limbs has never been delineated as a required service in the Plus contract. However, at the plan's request it was added to this document so plans would know if Artificial Limbs is covered in Oklahoma's Fee-For-Service program for Choice members. If a plan covered Artificial Limbs for adults as medically necessary, that was its option. Cost of Artificial Limbs as a benefit for children only is included in capitation payments. If Artificial Limbs were provided to adults, the MCO would have paid for them through plan operational savings. REQUIRED for children younger than 21 only.*	Coverage *NOT REQUIRED*	*No change for MCOs.* *REQUIRED*

Mammograms	Once every five years for women aged 35 through 39 and once a year for women 40 and older. *REQUIRED and included in capitation.*	No Change. *REQUIRED.*	Not applicable.
Treatment for Sexual Violence (Rape), Child Abuse, and Sexual Abuse	Covered, as medically necessary, with authorization by a Health Plan physician. Such exams are also covered if ordered by a court of competent jurisdiction or law enforcement agency in any situation. *REQUIRED and included in capitation.*	No Change *REQUIRED.*	No Change *REQUIRED*
Medical Transportation (Emergency and Non-Emergency)	Covered, as medically necessary, with authorization by Health Plan (includes transportation for wraparound services). *This is REQUIRED and included in capitation.*	No Change *REQUIRED*	No Change. *REQUIRED*
Therapy Services	Physical therapy, occupational therapy, and speech therapy services covered as medically necessary with authorization by Health Plan physician and in accordance with section 2.5.3.1 and 2.5.3.2. .*This is REQUIRED for children under 21 only and is included in capitation.*	Services *NOT REQUIRED*; optional.	No Change. *REQUIRED*

Transplants	For adults, plan pre-approved kidney, corneal, bone marrow/stem cells, heart, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart -lung organ transplants. *Adult cornea, kidney and bone marrow/stem cell transplants are the only services for which plans are at risk. Capitation includes these REQUIRED services. OHCA is at risk for every other covered adult transplant.*	The facility per diem rate for up to 15 days, and additional hospital charges associated with the transplant surgery up to a maximum payment of $150,000. *REQUIRED up to maximum, as noted. Plans are only at risk for cornea, kidney and bone marrow/stem cell transplants.*	The facility per diem rate, and additional hospital charges associated with the transplant surgery up to a maximum payment of $150,000. *REQUIRED up to the maximum, as noted.*

Behavioral Health Acute Inpatient Treatment and Medical Detoxification	Inpatient hospital care requiring twenty-four (24) hour supervision as a result of acute psychiatric illness or medical detoxification for substance abuse. Includes professional staff, under the direction of a physician, providing comprehensive care based on a treatment plan (on documentation of need) in a specialized behavioral health care unit in a hospital. *REQUIRED and included in capitation.*	15 inpatient hospital days per contract year, based on medical necessity. *Fifteen days is the REQUIRED minimum, although the plan has the option of providing more in Contract Year 2003.*	No change. *REQUIRED*
Inpatient Residential Treatment	*REQUIRED* for children and included in capitation. *NOT REQUIRED* for adults.	Not applicable.	No Change. *REQUIRED*

Outpatient Treatment for persons with psychiatric, substance abuse and/or domestic violence problems.	Individual Counseling: A therapeutic session with an individual conducted in accordance with a documented treatment plan focusing on treating his/her predetermined problem. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*
	Group Counseling: A therapeutic session with a group of individuals conducted in accordance with a documented treatment plan focusing on treating his/her predetermined problem. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*
	Family/Marital Counseling: A therapeutic session with family members/couples conducted in accordance with a documented treatment plan focusing on treating family/marital problems and goals. *REQUIRED and included in capitation*	No Change. *REQUIRED*	No Change. *REQUIRED*

Residential Treatment (restrictive)	Supervised 24-hour care in conjunction with an intensive treatment program for children or pregnant women with psychiatric and/or substance abuse problems who require more intensive care than outpatient treatment. Services shall include a minimum of 22 hours per week of therapeutic services to include but not be limited to: individual counseling, group and family counseling, rehabilitative and expressive therapies. *REQUIRED and included in capitation.*	Coverage *NOT REQUIRED for pregnant women; optional.*	Service may be limited to psychiatric services only. *REQUIRED*

Day Treatment	A time-limited, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. The program purpose is to provide intensive daily goal directed treatment to individuals experiencing acute symptoms or decompensating clinical conditions that severely impair their capacity to function adequately on a day-to-day basis, and who may be at risk of inpatient treatment without the daily program. The programs are normally provided at least three hours per day, five days a week. Treatment offered may include but need not be limited to: individual and group counseling; medication evaluation; family therapy; communication skills training; assertiveness training; stress management; problem solving techniques; and adjunctive therapeutic activities such as occupation therapy. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*

Outpatient Crisis Intervention	An unanticipated, unscheduled emergency intervention requiring prompt action to resolve immediate, overwhelming problems that severely impair the individual's ability to function or maintain in the community. Must be available 24 hours a day with the ability to provide face-to-face intervention to include but not limited to: 24 hour assessment, evaluation and stabilization; access to inpatient treatment; diagnosis and evaluation in external settings, such as jails and general hospitals; and, referral services. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*

Evaluation and Testing	A formal evaluation to establish problem identification, clinical diagnosis, or diagnostic impression. An evaluation shall include an assessment interview with the client and family, if deemed appropriate; may also include psychological testing, scaling of the severity of each problem identified for treatment; and/or, pertinent collaborative information. The evaluation will determine an appropriate course of assistance, which will be reflected in the treatment plan. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*
Intensive Outpatient Services (For mental health and/or substance abuse treatment.)	A therapeutic, structured, comprehensive program designed to provide treatment to improve or maintain a client's life management skills and ability to function in the community. The program is usually offered on a scheduled basis, a minimum of 2 hours per day at least 3 days a week. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*

Psychosocial Rehabilitation Services	Psychosocial rehabilitation services are designed to assist participants in obtaining or developing the skills, resources, abilities, and support systems necessary to establish self-sufficiency in the community. Participants shall be given the opportunity to be involved in all functions of the program including administration, intake and orientation of new participants, outreach, hiring and training of staff, advocacy and evaluation of program effectiveness. The goal of psychosocial rehabilitation services shall be improved client functioning through the use of an empowerment model. Clients shall be encouraged toward increased interdependency and optional functioning in the broader community. *REQUIRED for adults and included in capitation.*	No Change *REQUIRED*	Not applicable.

Homebased Services	Homebased services involve a range of services of which the majority are delivered in the client's home or in other natural settings in the community. Homebased services should be scheduled as the needs of each family dictates, taking into account the fact such services must often be offered during evening and weekend hours. In addition, Homebased services may be available on an emergency basis to all families participating in the program. Services to be provided may include but are not limited to: 24 hour crisis intervention with Homebased families; individual and family counseling; parent education and training on behavior management. Intensive therapy and support services to families of children with acute psychiatric problems for the purpose of preventing the child's removal from the home to more restrictive care. Homebased services are also appropriate for adults who are experiencing acute mental health episode or to a person designated as SMI. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*

Rehabilitative Case Management	Rehabilitative Case Management services work toward assuring access to services provided within the plan. Case management services also include referral, linkage, and advocacy in order to assist the client in gaining access to appropriate community resources. *REQUIRED and included in capitation.*	No Change. *REQUIRED*	No Change. *REQUIRED*
Therapeutic Foster Care (Residential Behavioral Management)	Therapeutic foster care (TFC) is a treatment modality to assist emotionally disturbed children in developing improved abilities to function in a non-institutional setting. It is designed to provide foster parents who are trained and prepared to provide in-home care to children who are experiencing serious emotional disturbance. TFC is provided by an agency approved by DHS with an existing contract with the Authority for this service. *NOT REQUIRED.*	Not applicable	Not applicable since children in state custody are excluded from enrollment in managed care.